

## **Comparative Analysis of Stakeholder Organization Position Papers in Response to Realignment of State Mental Health Functions**

During the summer of 2011, in response to legislative changes and direction from the Governor's Administration, the Department of Mental Health (DMH) convened a series of community mental health stakeholder meetings throughout the state. The meetings were designed to inform stakeholders about the changes to state level mental health administration and to listen to ideas, input, and concerns regarding the non-Medi-Cal functions currently performed by DMH. Stakeholders were asked to respond to a series of questions designed to elicit input about the placement of mental health functions at the state level. While many stakeholders found it challenging to provide specific recommendations about the placement of mental health functions, stakeholders expressed the need for inclusion, efficiency, streamlined data reporting processes, mental health leadership, improved access to and navigation of comprehensive services, and the ability to plan for the future with health care reform in anticipation of an integrated service system.

Over the course of the DMH Stakeholder Summer, DMH heard from over 1,000 consumers, family members, private providers, county representatives, local and state level consumer groups, and county organizations. The input gathered during the process was compiled, analyzed, and organized into a summary report. Five overarching themes emerged from the stakeholder input and were included in the final report (released October 2011):

1. Concerns Regarding State Level Mental Health
2. Benefits and Challenges of Local Control
3. Importance of Cultural Competence Leadership and Reducing Disparities
4. Integrity of the Mental Health Services Act (MHSA)
5. Role of Mental Health Consumers and Their Families

In addition to the stakeholders that attended the regional meetings, DMH sought input from government partners (such as the Mental Health Services Oversight and Accountability Commission, the Mental Health Planning Council, and the California Mental Health Directors Association, etc.), state level consumer advocacy organizations (such as NAMI CA, United Advocates for Children & Families, and the Mental Health Association in California, etc.), and other interested stakeholders throughout the state. Several organizations and individuals submitted letters and/or position papers expressing their recommendations for the future of non-Medi-Cal mental health functions at the state level. The recommendations included in these position papers were not limited to the placement of mental health functions. Many of the position papers advocated for the continuation of specific functions, such as the Office of Multicultural Services, and identified opportunities for process and system improvements. This supplement to the DMH Stakeholder Summary report captures the recommendations related to the placement of mental health functions detailed in the position papers submitted by these organizations.

Similar to the findings included in the DMH Stakeholder Summary Report, several themes emerged within the organizations' position papers. Although, as was the case with the regional stakeholders, there is no consensus regarding the ultimate placement of functions, there were several areas of alignment and commonality between all of the organizations. The stakeholder organizations seem to be in alignment on issues related to the importance of mental health leadership, integration, cultural competence and reducing disparities, and the importance of maintaining the principles and integrity of the Mental Health Services Act (MHSA) including the continued role of consumers and family members and the focus on wellness, recovery, and resilience.

### *Mental Health Leadership at the Highest Level*

The stakeholder organizations expressed the need for continued mental health leadership at the highest level possible within the state governmental structure. The United Advocates for Children and Families (UACF) CEO, Oscar Wright, clearly states the need for mental health leadership, "...it is imperative that mental health policy secures the highest placement in the state's governmental structure. It is critical that someone at a senior policy level, someone who understands the complexities and the plight of those affected...be appointed to ensure mental

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health care is a priority for future administrations.” The California Mental Health Planning Council (CMHPC) argues that transitioning all mental health services to the Department of Health Care Services (DHCS) would result in the “loss of influence on state policy.” While the California Mental Health Directors Association (CMHDA) supports the transition of mental health services to DHCS, CMHDA’s position paper notes the vital need for “on-going commitment to California’s community mental health system.”

### *Integrated Service Systems*

While maintaining mental health leadership is crucial, the organizations also recognize the value and need to move toward integrated service systems. With the implementation of the Affordable Care Act and health care reform efforts in California, stakeholders are preparing for the integration of primary care, mental health, and alcohol and drug services. The position papers address the need to integrate mental health services; however, there is some divergence among the organizations about the form of integration. The CMHPC advocates for the creation of a new behavioral health department modeled after the Substance Abuse and Mental Health Administration model at the federal level. CMHDA recommends the transition of Medi-Cal and non-Medi-Cal functions to DHCS, “given the major shifts in our nation’s health care policies, we believe an integrated focus on mental health, substance use, and physical health is more feasible if the various healthcare programs are administered by one state entity.” The Mental Health Association in California (MHAC), on the other hand, argues that none of these efforts (integrating within DHCS) toward integration go far enough. MHAC recommends, “developing a new department that should become a new Department of Health, Mental Health, and Alcohol and Drug Services and combine the knowledge, expertise, cultures, best practices, information system requirements and governance from all three presently separated systems.”

### *Cultural Competence and Reducing Disparities*

Along with the continued need for mental health leadership within the state and the move toward integration of services, almost all of the organizations convey the continued need to focus on cultural competence and reducing disparities. The Mental Health Services Oversight and Accountability Commission (MHSOAC) position paper cites the text of the Mental Health Services Act (MHSA) requiring the expansion of culturally and linguistically competent approaches for underserved populations. The MHSOAC’s mission, as indicated in its document, *MHSOAC’s Role in a Changing Mental Health Services Environment*, is to “provide oversight for eliminating disparities, promoting wellness, recovery and resiliency, and ensuring positive outcomes for individuals living with serious mental illness and their families.” CMHDA and the CMHPC also advocate for cultural competence and reducing disparities to remain a strong focus within the state structure (within DHCS or a new “CalSAMHSA” organization, respectively). The MHSA Partners Forum and the Racial & Ethnic Mental Health Disparities Coalition (REMHDCA) both strongly recommend the preservation of the current Office of Multicultural Services (OMS) within the state structure, regardless of the ultimate transition. Both the MHSA Partners and REMHDCA cite array of statewide programs to reduce disparities, oversight of counties’ cultural competence efforts, deep relationships with community and government partners, and cultural competence leadership as a testament to the “state’s commitment to health equity and the elimination of racial and ethnic health disparities for all Californians.”

### *Maintaining the Integrity of MHSA*

Finally, and most importantly, the stakeholder organizations agree upon the vital importance of maintaining the integrity and values of the MHSA. At the regional meetings, stakeholders expressed concerns about the loss of recovery principles and reverting back to the “medical model” if all state level functions are transitioned to DHCS. CMHDA’s position paper calls for DHCS to provide adequate, high level leadership that “would be charged with promoting mental health, wellness, resiliency, and recovery in California’s diverse communities.” Likewise, the National Alliance on Mental Illness (NAMI) California believes, “that any reorganization of the State Department of Mental Health should provide individuals living with mental illness with services and supports that increase health and recovery outcomes across the lifespan, are culturally and linguistically competent, and are integrated and coordinated to provide linkage to needed treatment and services regardless of funding stream.” As noted by the MHSOAC, the MHSA also obligates state leadership, specifically the MHSOAC, to “ensure that the perspective and

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participation of members and others suffering from severe mental health and their family members is a significant factor in all of its decisions.” The MHSOAC position paper goes on to state, “Carrying out this mandate requires active and productive engagement of consumers and family members across the lifespan, including diverse racial and ethnic stakeholder communities, with the expertise that comes from lived experience of mental illness.”

Although the initial round of regional stakeholder meetings has reached its conclusion, DMH is committed to an on-going stakeholder process as the transition of mental health services progresses. Stakeholders are invited to participate in the monthly stakeholder meetings that will guide the development of the Department’s transition plan. These stakeholder meetings will provide government partners, advocacy organizations, consumers, family members, and community members with an opportunity to further explore, dialogue, and perhaps reach consensus on the transition of non-Medi-Cal mental health functions from the Department of Mental Health to the new “home” for mental health services.

All of the stakeholder position papers referenced in this supplemental report are included as Appendices in the DMH Stakeholder Summary Report and are available online. For more information about the Community Mental Health Stakeholder process, or to obtain information about upcoming stakeholder meetings, please visit: [http://www.dmh.ca.gov/Services\\_and\\_Programs/Medi\\_Cal/Medi\\_Cal\\_Transfer.asp](http://www.dmh.ca.gov/Services_and_Programs/Medi_Cal/Medi_Cal_Transfer.asp).

### **Source Documents**

1. California Mental Health Directors Association Recommendations
2. MHSOAC’s Role in a Changing Mental Health Services Environment
3. CA Mental Health Planning Council’s Letter to Secretary Dooley
4. Mental Health Association in California Comments on DMH Reorganization
5. National Alliance on Mental Illness, California Position Paper
6. United Advocates for Children and Families Comments on DMH Reorganization
7. MHSA Partners Forum Comments
8. Racial and Ethnic Mental Health Disparities Coalition (REMHDCO) Comments on DMH Reorganization
9. California Emergency Management Agency (CalEMA) Comments on Reorganization
10. California Coalition for Mental Health Report
11. Considerations for Reorganization Report on California’s Departments of Mental Health and Alcohol and Drug Programs by Stella Lee and Richard Rawson